STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BLOOMINGTON	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction to the Investigation of Complaint IN00119843. Survey dates: November 26, 27, 28, 29, 30, and December 03, 04, and 05, 2012 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Survey team: Sharon Whiteman, RN, TC Susan Worsham, RN Marla Potts, RN Diana McDonald, RN Cheryl Mabry, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicare: 13	F0000	Disclaimer Statement:Submission of the Plan of Correction is not an admission that the deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal and State law."This Plan of Correction constitues a written allegation of substantial compliance with Federal Medicare and Medicaid requirements"	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 107 Other: 14 Total: 134 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on December 13, 2012; by Kimberly Perigo, RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview the facility failed to ensure a resident was provided privacy with personal care, for 1 of 40 residents who met the criteria for dignity. This had the potential to affect all the residents who resided on the unit, 12 of the facility census of 134. (Resident #54) Findings include: On 11/28/12 at 9:18 a.m.; upon entering the dementia unit, Resident #54 was observed to be sitting on the toilet, in the dinning room bathroom. CNA #7 and LPN #6 were present in the bathroom with Resident #54. The door to the bathroom was observed to have been fully opened, exposing the resident to eight other residents in the dining room; six females and two males, as well as to anyone walking up and down the hallway. During interview with the Unit Manager on 11/29/12 at 1:00 P.M., the Unit Manager indicated both staff	F0241	1. The corrective action accomplished for Resident #54 found to have been affected by the deficient practic are as follows: LPN #6 and CNA #7 were immediately in-serviced on providing privacy with personal care and provided disciplinary action by the Unit Manager upon notification of the deficient practice. 11/28/12 2. All residents who receive assistance from staff with toileting have the postential to be affected by this deficient practice. 3. The Alzheimer's care staff were educated by the Alzheimer's Care Director on Novemeber 28th 2012 regarding providing dignity and privacy while providing care.. Direct Care Staff that work outside the Alzheimer's Care Unit were in-serviced by the Director on Clinical Education on November 29th 2012. Direct Care staff will be re-inserviced. 01/02/13. New/Future staff will be educated in regards to dignity and privacy during general orientation.4. The Unit Managers/Designee will conduct daily random audits of care to ensure resident's dignity is being preserved while care is being	01/03/2013

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	members [LPN #6 and CNA #7] would be, "written up" for dignity related to not having the bathroom door closed to provide privacy. The clinical record for Resident #54 was reviewed on 11/29/12 at 10:42 A.M. The most recent MDS [minimum data set] assessment, dated 8/28/12, indicated the resident had severe cognitive impair and was dependent on staff for decision making. The MDS also indicated Resident #54 required extensive staff assistance with transfers and toilet use. The care plan, dated 6/9/10, included a problem, "restorative program for toileting." Approaches included but were not limited to "assist me to the bathroom when I get up in the am, after naps, before bed and once during night..." 3.1-3(t)		provided. Any identified concerns at that time will be corrected immediately.The audits will be conducted 5X a week to include all shifts and weekends. Audits will be turned into the Director of Nursing weekly for review. Any negative findings will be reported to the Quality Assurance Committee monthly for 3 months to look for trends or patterns. Any trends or patterns will have an action plan written and implemented. The Quality Assurance Committee will determine if further monitoring will be needed after the 3 month period. The Quality Assurance Team will review the audits for the prior 3 months to determine if further monitoring will be required after the 3 month period. If further monitoring is needed will continue on a month to month to basis.5. 01/03/13	

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F0244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review the facility failed to ensure grievances voiced by the resident council were acted upon. This had the potential to affect all residents who resided in the facility and wished to attend resident council. Findings include: During interview on 11/29/12 at 2:15 p.m., with the Resident Council President, Resident #49, he indicated meals were anywhere from 45 minutes to 2 hours late, and had been for two months. Resident #49 indicated last Saturday Church was supposed to be at 2:00 p.m., and the volunteers had to stand and wait to start Church, because the meal was so late, making the activity late too. Resident #49 indicated this had been brought up during resident council	F0244	1. Grievance dated 10-16-12 was resolved regarding rooms being cleaned daily, floors being swept and moped, windows and curtains being cleaned. 11/27/122. All residents have the potential to be affected by this deficient practice.3. Department Heads were re-educated on the grievance process and expectations on grievances by the Executive Director.01/02/13 Social Services and Activities Director were educated on the grievance process from resident council by the Executive Director 12/06/12 All grievances will be brought to morning Department Head meeting daily 5X a week to be reviewed for resolution. Grievances received on the weekend will be put in the Social Services box. Grievances not resolved within the 5 days will be discussed on why they are not resolved and Social Services will get back with the resident or family member on what is being done to resolve the grievance. Resident and or family member will be contacted once the grievance is resolved with the outcome of grievance.	01/03/2013

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	meetings, but nothing had been brought back to the council. Resident #49 indicated the facility responded to maybe half the residents' grievances. Resident #49 indicated part of the time the council just never heard a thing back nor saw any changes made. Resident #49 indicated the Activity Director helped the council with notes and things. During interview with the Activity Director on 11/29/12 at 2:25 p.m., she indicated grievances were placed on a form and given to the appropriate department head for a response. The Activity Director indicated the forms were suppose to be back by a certain date to be taken to the next month meeting, but sometimes this was done and sometimes not. The Activity Director indicated sometimes the department heads just did not respond until the next meeting day. The Activity Director provided a department response form which indicated, "date of council meeting 10/16/12." Documentation on the form further indicated, to department		Grievances that come from resident council will still be reviewied at the next resident council for their approval of the resolution. All grievances from resident council will be written separate not as a group if it pertains to missing clothes, room not clean, not getting a shower and etc. Residents were educated on the Grievance process on 12/18/12 at the Resident Council Meeting and were in agreement with the process.4. The Executive Director will review the grievance log weekly for timely follow-up. Social Services Director will monitor for any negative trends or patterns and report grievances and follow-up to the Quality Assurance Committee monthly for further recommendations. 5. 01/03/13	

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	head on 10/19/12, response due back to resident council representative 10/26/12, concerns were "room not cleaned daily, floors are not being swept and moped, windows and curtains are dirty, missing clothes." The response was returned to the resident council on 11/27/12. The only response was to the concern of missing clothes. There was no response to the cleaning. The Activity Director indicated she did not know about the food committee concerns as the dietary manager held those meetings immediately after the regular council meeting and she had no idea if notes were taken or not. During interview with the HFA [Health Facility Administrator] on 11/29/12 at 222 p.m., the HFA indicated she could find no notes from the food committee. The facility's policy and procedure for "Resident Council Process" dated 2009, was provided by the Director of Nursing, on 12/5/12 at 9:00 A.M. The policy indicated, "if two or more residents have issues, the			

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	Departmental Response Form [DRF] is to be utilized. The DRFs need to have a plan to correct the situation completed and signed by the appropriate department head, and then signed by the ED [Executive Director] at the next Council Meeting. The residents will decide whether the issues have been resolved [at least all but one resident agrees] or remains ongoing and needs to be readdressed using the same format...Council concerns also get added to the QA minutes." 3.1-3(l)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review the facility failed to ensure nursing staff followed a resident's care plan for urinary catheter positioning for 1 of 3 residents reviewed who met the criteria for having a urinary catheter. This contributed to the resident having received Macrobid [an anti-infective medication often used to treat a urinary tract infection]. (Resident #139) Findings Include: On 11/29/12 at 10:44 a.m., wound care was observed to be provided for Resident #139. Resident #139 was observed to rest in bed with 1/2 side rails in the up position. Resident #139 had a urinary catheter drainage bag, which was observed to be hanging on the side rail of the bed with urine back flowing in the tubing. Unit Manager #2 was observed to	F0282	1. The Unit Manager immediately coorected the positioning of the cathether tubing for Resident #139. The facility began in-servicing staff immdeiately on catheter tubing positioning.2. All residents who have a indwelling urinary catheter have the potential to be affected by this deficient practice.3. Direct care staff will be in-serviced on positioning of catheter tubing. 01/02/12 New/future staff will be educated on positioning of catheter tubing during general orientation.4. The Unit Manager/Designee will conduct random audits of care to ensure resident's catheter is positioned properly and not touching the floor. The audits wilt be conducted 5X a week to include all shifts and weekends by the Unit Manager/Designee for 4 weeks, then weekly for 8 weeks. Audits will include all shifts and weekends. The audits will be turned into the Director of Nursing weekly for review. Any negative findings will be reported to the Quality Assurance Committiee monthly for 3 months. Any trends or patterns identified will have a written action plan implemented. The Quality Assurance	01/03/2013

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	remove the drainage bag and to hook it on the bed frame. On 11/26/12 at 10:05 a.m., Resident #139 was observed resting in bed. The indwelling catheter drainage tubing was observed dragging on the floor. Dark yellow cloudy urine was observed in the catheter tubing. On 11/26/12 at 11:59 a.m., Resident #139 was observed in the Station 2 dining room seated in a wheel chair. Resident #139 was observed to have urinary drainage tubing dragging on the floor. The tubing was observed to be draining dark yellow urine with sediment and specks of red. Resident #139 was observed to drink 3 complete glasses of fluids while in the dining room. Resident #139 did not exhibit any signs or symptoms of being in pain while observed in the dining room. During interview of CNA #4 on 11/26/12 at 12:10 p.m., CNA #4 indicated Resident #139's urine did look like it had mucous and blood in it.		Committee will determine if further monitoring will be needed after the 3 month period. The Quality Assurance Committee will make the determination after reviewing the prior 3 month audits if further auditing is needed. If further monitoring is needed will continue on a month to month basis.5. 01/03/13	

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	On 11/30/12 at 8:27 a.m. and 10:01 a.m., Resident #139 was observed resting in bed. Resident #139's indwelling catheter drainage bag and tubing were observed to be on the floor. A dignity bag was observed hanging on the resident's bed rail. The catheter was draining dark yellow urine. Resident #139 did not exhibit and signs or symptoms of being in pain during this assessment. On 12/03/12 at 9:30 a.m., Resident #139 was observed resting in bed with 1/2 rails in the up position. The resident's urinary tubing was observed hanging over the top of the resident's bed railing with the urine back flowing in the tubing. The tubing was draining dark amber colored urine. Interview of RN #1 on 12/03/12 at 9:32 a.m., indicated she was not aware the tubing was over the top of the railing and she would change it immediately.			

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	Review, on 12/5/12 at 9:30 a.m., of Resident #139's clinical record indicated the following: A Medical Diagnoses list indicated Resident #139 had diagnoses which included, but were not limited to, Necrotizing Fascitis [death of tissue], other specified disorders of urinary tract, hypo-osmolality and/or hyponatremia. A physician's telephone order dated 11/30/12 indicated, "Obtain UA+ C&S [Obtain urinalysis and culture and sensitivity of urine]." A Progress Note dated 12/2/12, indicated, "Partial results received for UA+ [urinalysis] and posted to chart. Awaiting results." A Urinalysis report dated 12/02/12, indicated the following: Urinalysis - 12/02/12 - Reference Range Blood - 3 negative PH urine - 7			

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	7 Protein - 2+ negative Leukocytes - 4+ negative WBC, UR - >50 negative Epithelial cell - moderate negative Bacteria - Few negative An MDS [Minimum Data Set] assessment dated 09/25/12, indicated Resident #139 had severe cognitive impairment and was dependent on staff for daily decision making, required extensive assistance of staff with transfers, toilet use, and personal hygiene. The MDS indicated the resident had no urinary tract infections during the time of the assessment. An MDS dated 06/12/12 and MDS dated 05/08/12, indicated Resident #139 had no urinary tract infections during the assessment time periods.			

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	Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan, dated 05/13/12 with a target date of 01/10/13 indicated, "...I [Resident #139] have a poor response to others and the environment and limited ability to communicate...." A care plan dated 05/03/12 with a target date of 01/10/13 indicated, " Alteration in elimination of bowel and bladder indwelling urinary catheter ....Keep drainage bag of catheter below the level of the bladder at all times and off floor...." A Progress Note dated 11/30/12 at 4:02 p.m. indicated, "Resident [Resident #139] has sediment noted to catheter tubing. No odor noted and no c/o [complaint of] flank pain voiced. Consumed 480 CC [milliliters] of fluids at lunch and has drank 2 - 16 oz [ounce] glasses of water at bedside. New order written to obtain			

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	urine for UA+ [urinalysis] with C&S [culture and sensitivity]. Med lab notified, lab req [requisition] filled out. Will obtain after dinner et [and] change F/C [Foley Catheter] to obtain sample." A Progress Note dated 12/2/12 at 2:41 p.m. indicated, "Res [Resident #139] f/c [Foley Catheter] and ua [urinalysis] obtained using sterile tech [technique], res tolerated well." A Progress note dated 12/02/12 at 3:05 p.m. indicated, "Partial results received for UA+ and posted to chart. Awaiting final results." During interview of RN #5 on 12/04/21 at 9:49 a.m., RN #5 indicated Resident #139's lab results had just came in at 9:50 a.m. RN #5 indicated she was printing a copy, "right now" and would take care of it. RN #5 provided a copy of the final urine culture with a reported date of 12/03/12 and a "last reprint" date of 12/04/12. The report indicated positive growth for E-Coli [bacteria] and urine was positive for 3+ blood,			

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	2+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days." 3.1-35(g)(2)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview the facility failed to ensure a resident's urinary catheter was positioned to reduce risk for infection. This contributed to the resident being diagnosed with a urinary tract infection. This finding affected 1 of 3 residents reviewed for urinary catheters. (Resident #139) Findings Include: On 11/29/12 at 10:44 a.m., wound care was observed to be provided for Resident #139. The resident was observed to rest in bed with 1/2 side rails in the up position. The resident had a urinary catheter drainage bag which was observed to be hanging on the side rail of the bed with urine back	F0315	1. The Unit Manager immediately corrected the postioning of the catheter tubing for resident #139. The facility began in-servicing staff immediately on catheter tubing positioning.2. All residents who have an indwelling urinary catheter have the potential to be affected by this deficient practice.3. Direct Care staff will be in-serviced on positioning of catheter tubing. 01/02/13 New/Future staff will be educated in regards to positioning of catheter tubing during general orientation.4. The Unit Manager/Designee will conduct random audits of care to ensure resident's catheter is positioned properly and not touching the floor. Unit Manager/Designee will correct and provide education on any identified problems. The audits to be conducted 5X a week to include all shifts and weekends for 4 weeks then 1X a week for 8 weeks. Audits will be turned into the Director of Nursing	01/03/2013

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	flowing in the tubing. Unit Manager #2 was observed to remove the drainage bag and to hook it on the bed frame. On 11/26/12 at 10:05 a.m., Resident #139 was observed resting in bed. Indwelling catheter drainage tubing was observed dragging on the floor. Dark yellow cloudy urine was observed in the catheter tubing. On 11/26/12 at 11:59 a.m., Resident #139 was observed in the Station 2 dining room seated in a wheel chair. The resident was observed to have urinary drainage tubing dragging on the floor. The tubing was observed to be draining dark yellow urine with sediment and specks of red. The resident was observed to drink 3 complete glasses of fluids while in the dining room. During interview of CNA #4 on 11/26/12 at 12:10 p.m., CNA #4 indicated Resident #139's urine did look like it had mucous and blood in it.		weekly for review. Any negative findings will be reported to the Quality Assurance Committee monthly for 3 months. Any trends or patterns identified will have a written action plan implemented. The Quality Assurance Committee will determine if further monitoring will be needed after the 3 month period. The Quality Assurance Team will review the audits for the prior 3 months to determine if further monitoring will be required after the 3 month period If further monitoring is needed will continue on a month to month basis.5. 01/03/13	

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	On 11/30/12 at 8:27 a.m. and 10:01 a.m., Resident #139 was observed resting in bed. The resident's indwelling catheter drainage bag and tubing were observed to be on the floor. A dignity bag was observed hanging on the resident's bed rail. The catheter was draining dark yellow urine. On 11/30/12 at 10:07 a.m., CNA #4 and LPN #3 were observed to provide personal care to Resident #139. During the care, LPN #3 was questioned regarding Resident #139's urine looking cloudy and dark. LPN #3 indicated the color of the resident's urine, "comes and goes." LPN #3 indicated the resident did not have a UTI [urinary tract infectin] but Resident #139 just had sediment in the urine. Interview of the DON [Director of Nursing] on 11/30/12 at 3:25 p.m., the DON indicated nurses should report if residents have mucous and blood in their urine. DON indicated she would have the nurse call the doctor. The DON indicated the resident always			

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	drank all of her fluids. On 12/03/12 at 9:30 a.m., Resident #139 was observed resting in bed with 1/2 rails in the up position. The resident's urinary tubing was observed hanging over the top of the resident's bed railing with the urine back flowing in the tubing. The tubing was draining dark amber colored urine. Interview of RN #1 on 12/03/12 at 9: 32 a.m., indicated she was not aware the tubing was over the top of the railing and she would change it immediately. Review, on 12/5/12 at 9:30 a.m., of Resident #139's clinical record indicated the following: Nursing notes from 10/08/12 -11/14/12 lacked documentation supporting resident #139's indwelling catheter/urine was ever assessed or documented on during that time period. A nursing note dated 11/18/12 at			

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	18:36 p.m. indicated, "Note Text # 16 foley [sic] catheter changed secondary to obstructed flow, immediate return of cloudy yellow urine noted. Resident resistive while procedure in progress, sterile technique maintained." A Medical Diagnoses list indicated Resident #139 had diagnoses which included, but were not limited to, Necrotizing Fascitis [death of tissue], other specified disorders of urinary tract, hypo-osmolality and/or hyponatremia. A physician's telephone order, dated 11/30/12, "Obtain UA+ C&S [urinalysis for culture and sensitivity]." A Progress Note dated 12/2/12 indicated, "Partial results received for UA+ [The urinalysis test indicated Resident #139's urine was positive for infection] and posted to chart. Awaiting results." A Urinalysis report dated 12/02/12, indicated the following:			

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	Urinalysis - 12/02/12 - Reference Range Blood - 3 negative PH urine - 7 7 Protein - 2+ negative Leukocytes - 4+ negative WBC, UR - >50 negative Epithelial cell - moderate negative Bacteria - Few negative An MDS [Minimum Data Set] assessment dated 09/25/12, indicated Resident #139 had severe cognitive impairment, required extensive assistance of staff with transfers, toilet use and personal hygiene. The MDS indicated Resident #139 had no urinary tract infections during the time of the assessment. An MDS dated 06/12/12 and MDS dated 05/08/12, indicated Resident #139 had no urinary tract infections			

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	during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "...I [Resident #139] have a poor response to others and the environment and limited ability to communicate...." A care plan dated 05/03/12 with a target date of 01/10/13 indicated, " Alteration in elimination of bowel and bladder indwelling urinary catheter ....Keep drainage bag of catheter below the level of the bladder at al times and off floor...." A Progress Note dated 11/30/12 at 4:02 p.m. indicated, "Resident [Resident #139] has sediment noted to catheter tubing. No odor noted and no c/o [complaint of] flank pain voiced. Consumed 480 CC [milliliters] of fluids at lunch and has drank 2 - 16			

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	oz [ounce] glasses of water at bedside. New order written to obtain urine for UA+ [urinalysis] with C&S [culture and sensitivity]. Med lab notified, lab req [requisition] filled out. Will obtain after dinner et [and] change F/C [Foley Catheter] to obtain sample." A Progress Note dated 12/2/12 at 2:41 p.m. indicated, "Res [Resident #139] f/c [Foley Catheter] and ua [urinalysis] obtained using sterile tech [technique], res tolerated well." A Progress note dated 12/02/12 at 3:05 p.m. indicated, "Partial results received for UA+ and posted to chart. Awaiting final results." During interview of RN #5 on 12/04/21 at 9:49 a.m., RN #5 indicated Resident #139's lab results had just came in at 9:50 a.m. RN #5 indicated she was printing a copy "right now" and would take care of it. RN #5 provided a copy of the final urine culture with a reported date of 12/03/12 and a "last reprint" date of 12/04/12. The report indicated			

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	positive growth for E-Coli [bacteria] and urine was positive for 3+ blood, 2+ protein, 4+ Leukocytes, Moderate epithelial cells and few bacteria. Megan indicated she had just faxed the doctor with the lab results. Review of "Tabor's Cylclopedic Medical Dictionary 16 Edition" indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days. Documentation titled "Infection Surveillance Data Collection Form" was provided by the DON on 12/05/12 at 10:17 a.m. This form indicated, "...Catheterized Resident....Requires two of the following symptoms to be designated as an infection:...Fever (>100.4) or chills...New flank or suprapubic pain or tenderness...Change in			

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	color/character of urine....Change in mental status (e.g. confusion) or change in functional status (e.g. incontinence)." 3.1-41(a)(2)			

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F0362 SS=F	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. Based on observation and interview, the facility failed to employ sufficient staff to carry out the functions of the dietary department, in that meals were served late. Findings include: 1. During interview on 11/29/12 at 2:15 p.m., with the Resident Council President, he indicated meals were anywhere from 45 minutes to 2 hours late, and had been for two months. The Resident Council President indicated this concern had been brought up in resident council but nothing had changed so far. During interview with Resident #108 on 11/27/12 at 8:53 A.M., indicated meals were routinely late and had been for a several weeks. During interview with Resident #117 on 11/27/12 at 8:46 a.m, indicated meals were late routinely for several	F0362	1. Residents meal will be served within 15 minutes of the scheduled time. Residents will be told if their meal is running behind so that they do nothave to sit and wait with nothing to do. Sufficient Dietary support personnel will be provided to get meals out on time.2. All residents have the potential to be affected by this deficient practice.3. Dietary Department will be educated on the importance of getting residents meals out on time and notifying the Executive Director/Designee if meals are running behind so that we can share this information with our residents. Regional Manager of Health Care Services will educate dietary staff. 01/02/134. Dietary Manager/Designee will meet with residents monthly to discuss concerns and meal times. Food Committee notes will be kept and a copy given to the Executive Director.5. Dietary Manager/Designee will report to the Quality Assurance Committee monthly any meals that were late and why for further recommendations.6. 01/03/13	01/03/2013

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	weeks. 2. The Facility Administrator, provided on 11/26/12 at 1:00 p.m., a list of meal times, which indicated lunch was to be served 11:55 a.m. on Reminiscence, 12:00 noon on Horizons, 12:30 p.m. in the Main Dining room and hot carts., with breakfast times for Horizons was 7:20 a.m. and hot carts 7:30 a.m. On 11/26/12 Horizons was observed to have received their lunch trays at 12:40 P.M. [40 minutes late] On 11/27/12 Reminiscence was observed to have received their lunch trays at 12:33 p.m. [approximately 35 minutes late]. On 11/27/12 the Main Dining room was observed to have received their first tray at 12:48 p.m., with the last tray served at 1:22 p.m.. Residents were observed waiting for the meal service from 12:15 p.m. until the meal was served at 1:22 p.m. Numerous residents were heard to comment on the lateness of meals, and the desire for the facility to just tell them when to be there so they did not have to sit and wait with nothing			

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	to do. 3. See Federal/State Deficiency 371 for more information related to staffing issues. 3.1-20(h)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure walk-in cooler and freezers, milk coolers, ice cream freezers, storage bins, carts which held clean dishes and kitchen supplies, metal trays, oven, toaster, vents over stove, kitchen floor, and storage and food carts were clean. This had the potential to effect 134 of 134 residents who ate meals prepared in the kitchen. Findings Include: During initial kitchen tour on 11/26/12 at 9:00 a.m., with the Dietary Manager in Training #1 present, the entire kitchen floor was observed to be soiled with black and sticky matter. Dietary Manager in Training #1 indicated he just walked in the kitchen, "this morning" and he had no idea when the last time the kitchen	F0371	1. The entire kitchen floor, the doors of the walk in cooler, doors of the walk in freezer, all food carts, all open carts, the rack which holds clean dishes, both hand wash sinks, the cart in the walk in cooler, the 2 milk coolers, the metal table holding flour and sugar bins, the flour and sugar bins, the ice cream freezer, the storage bins which held sweetner/sugar packets, the toaster, 6 metal trays, the storage cart, metal vents over the top of the stove and the top of the oven were all cleaned on 12/04/12. The non-working fan in the freezer was replaced on 12/06/12.2. All residents have the potential to be affected by this deficient practice.3. Health Care Services will provide a staff person that their only focus is cleaning to maintain sanitary conditions in the kitchen at all times. Health Care Services dietary staff will be re-educated on the importance of maintaining sanitary conditions in the kitchen at all times by the Health Care Services Regional Manager by 01/02/134. Dining Services Manager/Designee will evaluate	01/03/2013

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	floor was mopped. Dietary Manager in Training #1 indicated he had a support group today to help out in the kitchen. During second tour of the kitchen on 12/04/12 at 2:00 p.m., with Dietary Manager in Training #1 present the following soiled areas/containers/kitchen equipment were observed: 1. The entire kitchen floor continued to remain soiled with sticky matter. 2. The doors of the walk-in cooler and walk-in freezer were observed to be soiled with sticky/grimy buildup. 3. Three food carts were observed to be soiled with greasy/grime buildup on shelving and edges. 4. Five of five open carts used to carry food trays were observed to be soiled with dust/greasy buildup. 5. A rack which held clean dishes was observed to be soiled with dust/dirt buildup. 6. A hand wash sink was observed to be soiled with a buildup of scum. 7. A cart in the walk-in refrigerator was observed to hold 2 trays		kitchen sanitation 5X a week. Evaluations will be completed on an audit sheet and will be turned into the Excutive Director wekly for 12 weeks. At the end of 12 weeks the Quality Assurance Committee will evaluate and determine if further monitoring is needed..5. Executive Director/designee will make a round in the kitchen 3X a week for 2 weeks, 2X a week for 2 weeks, 1X a week for 4 weeks then 1X a month. Any identified concerns will be corrected at that time. Executive Director will report to the Quality Assurance Committee any negative outcomes monthly for further recommendations.01/03/13	

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	containing drinks to be served to the residents. The cart was observed to have dried food particles on it. 8. The walk-in freezer was observed to have a a thick layer of frost [approximately 1 inch] on the sides of the freezer and a thin layer of frost on frozen food boxes. 9. Two milk coolers were observed to have a build up of ice and milk spilled in the bottom and dirt/debris in the bottom. 10. A metal table holding flour and sugar bins was observed to be soiled with dirt and dust and sticky matter was observed on the outside of the flour/sugar bins. 11. An ice cream freezer was observed with ice buildup and dirt in the bottom of the freezer. 12. A storage bin which held cups and lids was observed to be soiled with greasy/dusty matter. 13. A storage bin which held sweetener/sugar packets was observed to be soiled with a dusty/greasy film. 14. A toaster was observed to have a greasy/dusty buildup on the top and sides.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	15. Six metal trays were observed to have blackened buildup around the edges. 16. A storage cart which contained clean trays was observed to be soiled with dust buildup. 17. Metal vents over the top of the stove was observed to be soiled with dust buildup. 18. The top of the oven was observed to be soiled with a greasy film. Interview of Dietary Aide #12 on 12/04/12 at 2:10 p.m., indicated Dietary Aide #11 used to do the deep cleaning in the kitchen, but the Dietary Aide #11 no longer was an employee. 3.1-21(a)(3)			

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